PRINTED: 07/13/2011

EPARTMENT OF HEALTH AND HUM	FORM APPROVED					
ENTERS FOR MEDICARE & MEDIC	ENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 B. WING		COMPLETED		
	155669			06/15/2011		
		D. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			395 WESTFIELD RD			
			1			

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
 RIVERV	/IEW TCU	395 WESTFIELD RD NOBLESVILLE, IN46060				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	A Life Safety Code Recertification and a State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 011046 Provider Number: 155669 AIM Number: NA Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Riverview TCU was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 This facility is located on the fourth floor of a fully sprinklered building determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 25 and had a census of	K0000	The creation and submission of this Plan of Correction does not constitude an admission by this provider of any conclusion set forth in the statement of dificiencies, or of any violation of regulations. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests that this Plan of Correction be accepted as written. AddendumWe are sending an addendum to K32 and K34. Due to the non approval of the current Fire Safety Evaluation System (FSES) We have requested an updated survey to meet your request. Therefore we are requesting and extention to the original date to 8/15/11.This provider respectfully requests a Post Survey Review after 8/15/11.If there are any further questions please contact David Woods at 317-770-2870.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FZWF21

Facility ID:

011046

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155669		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/15/2	ETED	
	PROVIDER OR SUPPLIER	!!	1	STREET A	DDRESS, CITY, STATE, ZIP CODE STFIELD RD SVILLE, IN46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Safety Code Special 06/17/11. The facility was	Robert Booher, REHS, Life list-Medical Surveyor on found not in compliance entioned regulatory					
K0032 SS=F	other, are provided section of the build exits may be a hor 19.2.4.2 Based on observer facility failed to compartments whome exit providing travel to an exit of practice affects a facility including visitors. Findings include Based on observer Director during a 11:30 a.m. to 12: TCU has two emis a horizontal exits.	ation and interview, the ensure 2 of 2 smoke ere provided with at least ag a continuous path of discharge. This deficient ll occupants in the gresidents, staff and	K	0032	ADDENDUM ON 7/5/2011TH PLAN OF CORRECTION FO 0032 IS BEING AMENDED TO INCLUDE AN UPDATED FIF SAFETY EVALUATION SYS (FSES). RTM CONSULTANTINC, HAVE BEEN CONTACTAND PLAN AN INITIAL VISIT RIVERVIEW HOSPITAL ON 7/11/2011 TO DISCUSS THE PLAN TO COMPLETE AN UPDATED (FSES) SURVEY RIVERVIEW RESPECTFULING REQUEST A 30 DAY EXTENTION IN ORDER TO COMPLETE THIS NEW SUREVEY THAT WILL ADDRESS EMERGENCY MOVEMENT ROUTES. TOU NEW DATE OF COMPLETIC WOULD BE 8/15/20111. What	DR K FO RE TEM FS FED F TO E A LY	08/15/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155669	(X2) M A. BUII B. WIN	LDING	01	(X3) DATE S COMPL 06/15/2	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN46060					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
	second exit is an not connect to an the exterior. Bas time of observation Director acknown compartment is a	s two exit stairwells. The exit stairwell that does a exit discharge directly to sed on interview at the ion, the Executive ledged each smoke not provided with at least ging directly to the hilding.			corrective action(s) will be accomplished for those patie found to have been affected the deficient practice; This fa does not feel that any patien staff or visitor had the poten be negatively affected by this alleged deficient practice be this exit has been assessed Fire Safety Evaluation Syste (FSES) which demonstrates equivalent compliance with the analysis when scoring the total Riverview facility. Please set attached FSES survey and purvey conducted by Division Long Term Care, Indiana State Department of Health regard 0032.2. How other patients having the potential to be affected by the same deficient practice be identified and what correct action will be taken; We don feel that any patients have the potential to be negatively affected by this alleged deficient practice because we feel that we men intent of the law due to the Fanalysis that was completed this facility. (Safety parameters#10 for Emergen Movement Routes scored deficient (-2) to address this condition)3. What measures be put into place or what system conducted at least quarterly which time this exit will be conducted at least quarterly which time this exit will be evaluated to be unobstucted.	by cility tt, cilal to secause by mental secause		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER: 155669	(X2) MULTIPLE CO	01	COMPLETED 06/15/2011
		100009	B. WING	A DDDDEGG CHTM CT: TT CT	00/10/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD	
RIVERVI	EW TCU		l l	ESVILLE, IN46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0034 SS=F	exits are in accord 19.2.2.4 Based on observation facility failed to protected path of discharge for 3 owith LSC section requires every sure discharge into a procourt having directly or into an exit parassageways share other than the ensurement of the exit passageway the remainder of hour fire resistant	ation and interview, the provide a continuous fravel to an exit of 3 exits in accordance as 7.2.3.5. LSC 7.2.3.5 nokeproof enclosure shall public way, into a yard or ct access to a public way, ssageway. Such exit ll be without openings	K0034	FSES will be reviewed periodically to document chain the facility. 4. How the corrective actions(s) will be monitored to ensure the def practice will not recur, i.e. wo quality assurance program in put into place: This corrective action will be monitored through the practice will not recur, i.e. wo quality assurance program in put into place: This corrective action will be monitored through the monthly checlist by a CQI committee and reviewed by quality assurance team at least quarterly. The facility Administrator and Director of Engineering or appointed the members will monitor compliance. ADDENDUM ON 7/5/2011T PLAN OF CORRECTION FOUR OF CORRECTION FOUR AND PLAN OF CORRECTION FOUR AND PLAN AN INITIAL VIS RIVERYIEW HOSPITAL ON 7/11/2011 TO DISCUSS THOUGH PLAN TO COMPLETE AN UPDATED (FSES) SURVEN RIVERVIEW RESPECTFUL REQUEST A 30 DAY EXTENTION IN ORDER TO COMPLETE THIS UPDATE SUREVEY THAT WILL ADDRESS EMERGENCY MOVEMENT ROUTES. TO NEW DATE OF COMPLETI WOULD BE 8/15/20111. Who corrective action (S) will be	icient that will be e pugh a cast of am 08/15/2011 OR K TO RE STEM TS CTED IT TO I E A Y. LLY DO ID U ON

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FZWF21 Facility ID:

011046

If continuation sheet

Page 4 of 8

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 01			COMPLETED	
		155669	B. WING 06/15/2011			011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2		1				
DI) (ED) (I	F147 T-011				ESTFIELD RD			
RIVERVI	EW ICU			NORFE	SVILLE, IN46060			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	\downarrow	TAG	DEFICIENCY)		DATE	
	facility including	g residents, staff and			accomplished for those patie			
	visitors.				found to have been affected			
					the deficient practice;This fac			
	Eindings include				does not feel that any patien			
	Findings include	··			staff or visitor had the potent			
					be negatively affected by this			
	Based on observ	ations with the Executive			alleged deficient practice bed			
	Director during	a tour of the facility from			this exit has been assessed	•		
	I -	:15 p.m. on 06/15/11, the			Fire Safety Evaluation Syste (FSES) which demonstrates	111		
		which the TCU is located			equivalent compliance with t	hier		
					analysis when scoring the to			
		vo smoke compartments			Riverview facility. Please see			
	and has three sta				attached FSES survey and p			
	Additionally, the	e fire resistance rating of			Survey conducted by Divisio			
	the three exit end	closures on the first floor			Long Term Care, Indiana Sta	ate		
	of the hospital to	the exit discharge door			Department of Health regard	ing K		
	is less than two l				0034.2. How other patients			
					having the potential to be aff			
		time of observation, the			by the same deficient practic			
	Executive Direct	tor acknowledged each of			be identified and what corre			
	the three exit dis	charge passageways are			action(s) will be taken; We do			
	not separated fro	om the remainder of the			feel that any patients have the potential to be negatively affert			
	_	o hour fire resistance			by this alleged deficient prac			
	rating.				because we feel that we mee			
	Tating.				intent of the law due to the F			
	2 1 10(b)				analysis that was completed			
	3.1-19(b)				this facility. (Safety			
					parameters#10 for Emergen	су		
					Movement Routes scored			
					deficient (-2) to address this			
					condition)We request a waiv			
					this requirement based on th			
					FSES which has been accep			
					by JCAHO and prior Indiana			
					Department of Health survey			
					where the facility was found			
					in substantial compliance wit			
					requirements of participation			
					(Please note in the attached Safety Code Recertification a			
					Salety Code Receitification a	ailu		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMB.		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI A. BUILDING	nstruction 01	(X3) DATE SURVEY COMPLETED	
		155669	B. WING		06/15/20	011
NAME OF F	PROVIDER OR SUPPLIER		395 WE	DDRESS, CITY, STATE, ZIP CODE STFIELD RD SVILLE, IN46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0144 SS=F	Generators are ins	spected weekly and had for 30 minutes per	TAG	State Licensure Survey conducted at this facility by Division of Long Term Care, Indiana State Department of Health regarding Life Safety 0034) Survey stated "Correct obviated. Passed FSES" Quasurance environmental to will be conducted at least quarterly at which time this ewill be evaluated to be unobstructed.3. What measure will be put into place or what systemic changes will be made to ensure the the deficient prodoes not recur; Quality Assurenvironmental tours will be conducted at least quarterly which time this exit will be evaluated to be unobstructed at least quarterly which time this exit will be evaluated to be unobstructed from the faction of the product of the put into place. This corrective action be monitored through a more checklist by a CQI committee reviewed by quality assurant team at least quarterly. The facility Administrator and Dir of Engineering or appointed members will monitor compliance.	the f K ction pality purs exit ures t akde ractice rance at d. ally to cility. s(s) the cur, will othly e and ce rector	DATE
	Based on observa	ation and interview, the	K0144	What corrective action(s) be accomplished for those	will	07/15/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
		155669	B. WING 06/15/2011			011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER				STFIELD RD		
RIVERVIE	-W TCII			1	SVILLE, IN46060		
				L	OVILLE, 114-0000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	-	ensure 1 of 3 emergency			patients found to have been		
	generators was e	quipped with a remote			affected by the deficient practice;No patients were		
	manual stop. NF	FPA 99, Health Care			identified as being affected b	v this	
	Facilities, 3-4.1.1	1.4 requires generator sets			alleged deficient practice due		
	installed as altern	nate power sources shall			the fact that an emergency		
		nents of NFPA 110,			generator was available for t		
	•	ergency Standby Power			TCU that did have a manual	stop	
		0 , ,			available for emergencies.		
	-	110, 3-5.5.6 requires			Emergency Generator Remo		
1		ions shall have a remote			plan. 2. How other patients	Jei	
	_	on of a type similar to a			having the potential to be aff	ected	
	break glass static	on located outside of the			by the same deficient practic		
	room where the p	orime mover is located.			be identified and what correct		
	This deficient pra	actice could affect			action(s) will be taken;We do		
	residents, staff ar	nd visitors.			not believe that any patients		
	,				the potential to be negatively		
	Findings include	-			affected by this alleged defic practice because we feel tha		
	i manigs merade	•			were meeting the intent of th		
	Danid an alasama	-tiith th - Eti			in providing a generator that		
		ation with the Executive	the ability to manually be stopped				
	_	tour of the facility from			in an emergency. Generator		
		15 p.m. on 06/15/11, no			be inspected weekly and		
	evidence of a ren	note shut off device was			exercised under load for 30		
	found for the em	ergency generator			minutes per month in accord	ance	
	servicing the long	g term care facility in the			with NFPA 99.Consulting Emergency Power Company	,	
		on interview at the time			(Cummins Crosspoint) has b		
	•	ne Executive Director			contacted and a plan to insta		
	acknowledged th				remote stop has been develo		
	•	off for the generator.			What measures will be pu	tinto	
	chicigoney shut (on for the generator.			place or what systemic chan		
	3.1-19(b)				will be made to ensure that the	ne	
					deficient practice does not	otod	
					recur;Generator will be inspe weekly and exercised under		
					for 30 minutes per month in	ioau	
					accordance with NFPA		
					99.Consulting Emergency Po	ower	
					(Cummins Crosspoint Power		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER: 155669	A. BUILDING	01	li i	E SURVEY PLETED 2011
		100009	B. WING			2011
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU		395	ET ADDRESS, CITY, STATE, ZIP C WESTFIELD RD BLESVILLE, IN46060	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	PRRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAU	REGULATORY OR	Loc IDENTIF TING INFORMATION)	IAG	Systems) Company utilized to help notify on any future NFPA changes.4. How the action(s) will be more ensure the deficient not recur, i.e., what assurance program into place; Generator inspected weekly an under load for 30 mi month in accordance 99. As part of quality program the remote switch will be monitor. Riverview Engineering department monthly the generator is executed. Consulting con utilized to help notify on any future NFPA changes during PM visits.	will be y the Hospital code corrective nitored to practice will quality will be put r will be ad exercised inutes per e with NFPA assurance manual stop ored by ng , during time rcised under mpany will y the Hospital code	DAIE